



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MARK JOHNSON
PO BOX 741865
DALLAS TX 75374

Respondent Name

HARTFORD FIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-13-1480-01

MFDR Date Received

FEBRUARY 13, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please accept the following Position Statement as required by Rule 133.307 (C)(2)(f).

(F) a position statement of the disputed issue(s) that shall include:

(i) a description of the health care for which payment is in dispute,

DESIGNATED DOCTOR EXAM

(ii) the requestor's reasoning for why the disputed fees should be paid or refunded,

CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS

(iii) how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues, and

THE CURRENT RULES ALLOW REIMBURSEMENT."

Amount in Dispute: \$850.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No insurance carrier response received

Response Submitted by: n/a

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 04, 2012	CPT Code 99456-W5-NM and 99456-RE-W8	\$850.00	\$850.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, 37 Texas Register

3833, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
No explanation of benefits received

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. Requestor billed with CPT Code 99456-W5-NM in the amount of \$650.00 with one unit and CPT Code 99456-RE-W8 in the amount of \$700.00 with one unit for a Maximum Medical Improvement (MMI), Impairment Rating (IR) and Return to Work (RTW) examination.

Review of the submitted documentation provided a DWC-32 request shows an examination was requested to address Maximum Medical Improvement (MMI), Impairment Rating (IR) and Return to work (RTW).

Per Administrative Code §134.204 (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows, (A) If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier "NM" shall be added,

(3) The following applies for billing and reimbursement of an MMI evaluation, (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350.

Therefore, CPT Code 99456-W5-NM is supported.

The total MAR for CPT Code 99456-W5-NM is \$350.00

Per Administrative Code §134.204 (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows, (3) The following applies for billing and reimbursement of an MMI evaluation, (k) The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be \$500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.

Therefore, CPT Code 99456-RE-W8 is supported.

The total MAR for CPT Code 99456-RE-W8 is \$500.00

2. The respondent issued payment in the amount of \$0.00. Based upon the documentation submitted, additional reimbursement in the amount of \$850.00 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent

to remit to the requestor the amount of \$850.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	9/20/13
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.